

# HEALTH BENEFIT COMPARISON

Effective January 1, 2010



This comparison is only a summary of benefits. Benefits will be administered as described in each plan's subscriber agreement or plan document. For further detail, refer to those documents or call Wellmark Blue Cross Blue Shield. (Health plan options differ by bargaining unit/status.)

	Managed Care Plans	Preferred Provider Organization (PPO) Plan		Indemnity Plans	
	Blue Access Blue Advantage	Iowa Select		Program 3 Plus	Deductible 3 Plus
		In Network (Select Provider)	Out-of-Network (Non-Select Provider)		
<b>General Conditions of Coverage</b>					
<b>Benefits Available from Non-Participating Providers</b>	None, unless prescribed, referred and approved by a participating physician, or in an emergency medical condition, or with prior authorization from the plan (when required).	Normal plan benefits for select providers. You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.	Normal plan benefits for non-select providers. You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.	Normal plan benefits. You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.	Normal plan benefits. You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.
<b>Coinsurance Percentage</b>	Varies; see below.	10%.	20%.	20%. All services.	20%. All services.
<b>Deductible</b>	None.	Single: \$250. Family: \$500.  Applies to both inpatient and outpatient services. Waived for services provided in office/clinic setting of select provider.  Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.	Single: \$250. Family: \$500.  Applies to both inpatient and outpatient services.  Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.	Single: \$300. Family: \$400  Inpatient services only.  Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members. The entire family deductible must be met before benefits payments are made.	Single: \$300. Family: \$400  Applies to <u>all</u> services. Any portion of deductible satisfied in last three months of year will be credited for following year as well.  Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members. The entire family deductible must be met before benefits payments are made.
<b>Dependent Child Age Limit</b>	<ul style="list-style-type: none"> <li>- Unmarried children under age 25 and reside in the State of Iowa.</li> <li>- Unmarried children that are full-time students in an accredited institution of postsecondary education regardless of age.</li> <li>- Totally and permanently disabled, physically or mentally, children regardless of age. The disability must have existed before the child turned age 25.</li> </ul>				

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<b>Medical Out-of-Pocket Maximum</b>	Single: \$750. Family: \$1500.  All copayments go toward out-of-pocket limit with the exception of prescription drug copayments.  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.	Single: \$600. Family: \$800.  Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, except \$15 office visit copayment, go toward out-of-pocket limit. Emergency Room copayment continues to apply after out-of-pocket limit is met.  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.  Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	Single: \$600. Family: \$800.  Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, except \$15 office visit copayment, go toward out-of-pocket limit. Emergency Room copayment continues to apply after out-of-pocket limit is met.  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.  Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	Single: \$600. Family: \$800.  All deductibles, coinsurance, and copayments, except \$15 office visit copayment, go toward out-of-pocket limit.  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. The entire family out-of-pocket must be met before benefits payments are made.  Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	Single: \$600. Family: \$800.  All deductibles, coinsurance, and copayments go toward out-of-pocket limit.  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. The entire family out-of-pocket must be met before benefits payments are made.
<b>Lifetime Benefit Maximum</b>	None.	None.		None.	None.
<b>New Employee Preexisting Condition Waiting Period</b>	None.	11 months.		11 months.	11 months.

## Your Payment Responsibilities

### MEDICAL

<b>Accidents</b>	\$10 copayment office visit. \$50 copayment for ER, waived if admitted.	10%, deductible waived in office setting.	20%, after deductible. Emergency care covered at in-network level.	0%, no deductible for all treatment within 72 hours of accident.	0%, after deductible for all treatment within 72 hours of accident.
<b>Allergy Treatment</b>	\$10.00 copayment per visit.	10%, deductible waived in office setting.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Ambulance</b>	0% if medically necessary/emergency medical services.	20%, after deductible.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Blood, Blood Plasma, Blood Serum</b>	0% if authorized.	10%, after deductible.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Chiropractor</b>	\$10.00 copay if approved provider.	10%, deductible waived in office setting.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Dental Accident Care</b>	20% if authorized by Wellmark for injury to sound natural teeth. Services must be within 6 months of injury and injury must have occurred while member enrolled in plan.	10%, deductible waived in office setting. Limited to services provided within 72 hours of accident.	20%, after deductible. Limited to services provided within 72 hours of accident.	0%, no deductible for services provided within 72 hours of accident. 20% thereafter for a maximum of 6 months from injury.	0%, after deductible for services provided within 72 hours of accident. 20% thereafter for a maximum of 6 months from injury.

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	Blue Access Blue Advantage	Iowa Select		Program 3 Plus	Deductible 3 Plus
		In Network (Select Provider)	Out-of-Network (Non-Select Provider)		
<b>Durable Medical Equipment</b>	20% if prescribed by a participating provider and obtained from a supplier authorized by Wellmark.	10%, after deductible.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Emergency Room (ER Care)</b>	\$50.00 copayment; waived if admitted.	\$50.00 copayment; waived if admitted. Copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.		0%, no deductible. Also see section on "Accidents."	0%, after deductible. Also see section on "Accidents."
<b>Eyeglasses</b>	Not covered.	Not covered.		Not covered.	Not covered.
<b>Hearing Aids</b>	Not covered.	Not covered.		Not covered.	Not covered.
<b>Hemodialysis</b>	0% if obtained in a center authorized by Wellmark.	10%, after deductible.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Home Health Care</b>	0% if authorized by Wellmark.	10%, after deductible. Precertification required.	20%, after deductible. Precertification required.	20%, no deductible. Precertification required.	20%, after deductible. Precertification required.
<b>Hospice Care</b>	0% if medically authorized by Wellmark.	10%, after deductible. Precertification required.	20%, after deductible. Precertification required.	20%, no deductible. Precertification required.	20%, after deductible. Precertification required.
<b>Infertility Services</b>	Not covered.	\$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.		\$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.	\$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.
<b>Inpatient Physician Services</b>	0% if authorized.	10%, after deductible.	20%, after deductible.	20%, after deductible.	20%, after deductible.
<b>Inpatient Room &amp; Board</b>	0% if authorized. Semi-private basis, unless medically necessary to use a private room. May require prior approval.	10%, after deductible. No limit on medical surgical days. Precertification of admission required by select provider.	20%, after deductible. No limit on medical surgical days. Precertification of admission required by member.	20% after inpatient services deductible. No limit on medical surgical days. Precertification of admission required by member.	20%, after deductible. No limit on medical surgical days. Precertification of admission required by member.
<b>Inpatient Supplies, Drugs, Medicines, etc.</b>	0% if authorized.	10%, after deductible.	20%, after deductible.	20%, after deductible.	20%, after deductible.
<b>Inpatient Surgery</b>	0% if authorized.	10%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.
<b>Inpatient Tests, ICU, Operating Room, Specialized Care, etc.</b>	0% if authorized.	10%, after deductible.	20%, after deductible.	20%, after deductible.	20%, after deductible.
<b>Large Case Management</b>	Alternative care set up on a case by case basis by plan.	Alternative care set up on a case by case basis by plan.		Alternative care set up on a case by case basis by plan.	Alternative care set up on a case-by-case basis.
<b>Maternity</b>	0% for delivery. \$10.00 copayment for initial visit; remaining pre- and post-natal visits paid in full.	10%, deductible waived in office setting for pre- and post-natal visits.	20% after deductible.	20%, no deductible for pre- and post-natal office visits.	20%, after deductible.
<b>Nursing Facility Providing Skilled Care</b>	0%. Maximum of 120 days per member per calendar year.	10% after deductible. Unlimited days. Precertification required.	20% after deductible. Unlimited days. Precertification required.	20% after deductible. Unlimited days. Precertification required.	20%, after deductible. Unlimited days. Precertification required.

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<b>Occupational Therapy</b>	\$10.00 copayment per visit. Maximum 60 visits per member per year.	10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.
<b>Office Visit</b>	\$10.00 copayment per visit.	\$15 copayment once per date of service <b>for exam only</b> ; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket limit.</b> 10% coinsurance, deductible waived in office setting for other office services.	\$15 copayment once per date of service <b>for exam only</b> ; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket limit.</b> 20% coinsurance, after deductible, for other office services.	\$15 copayment once per date of service <b>for exam only</b> ; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket limit.</b> 20% coinsurance, no deductible for other office services.	20%, after deductible.
<b>Organ Transplants</b>	Heart, heart/lung, lung (single and double), liver, pancreas, kidney/pancreas, kidney, cornea, small intestine, autologous bone marrow, and allogeneic bone marrow transplants 100% covered if authorized by Wellmark. No coverage if experimental or in a nonauthorized facility.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.		Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.
<b>Outpatient Chemotherapy</b>	\$10 copayment per visit.	10%, deductible waived in office setting.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Outpatient Surgery</b>	0% if authorized.	10%, after deductible. Required for certain procedures. Approval obtained by select provider.	20%, after deductible. Required for certain procedures.	0%, no deductible. Required for certain procedures.	0%, after deductible. Required for certain procedures.
<b>Outpatient Surgery Setting</b>	Participating physician will determine appropriate surgical setting.	Required for certain procedures. Select provider obtains approval.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.
<b>Physical Therapy</b>	\$10.00 copayment per visit. Maximum 60 visits per member per year.	10%, deductible waived in office setting.	20%, after deductible.	20%, no deductible.	20%, after deductible.
<b>Preapproval of Inpatient Admissions</b>	Required.	Required.		Required.	Required.
<b>Prosthetic Appliances and Other Devices</b>	20% if authorized by participating physician and obtained from an authorized supplier.	10%, after deductible.	20%, after deductible.	20%, no deductible.	20%, after deductible.

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Respiratory Therapy	\$10.00 copayment per visit. Maximum 60 visits per member per year.	10%, after deductible. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Payable, inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.
Routine Eye Exam	\$10.00 copayment per visit. Limit of one exam per member per year.	10%, deductible waived. Limit to one exam per member per year.	20%, deductible waived. Limit to one exam per member per year.	Not covered.	Not covered.
Routine Hearing Exam	\$10.00 copayment per visit. Limit of one exam per member per year.	10%, deductible waived. Limit of one exam per member per year.	20%, deductible waived. Limit of one exam per member per year.	Not covered.	Not covered.
Routine Physicals	\$10.00 copayment per visit, excluding travel, employment, or athletic related/required.	10%, deductible waived in office setting, excluding travel, employment or athletic related/required. Limit of one physical per member per year.	20% after deductible, excluding travel, employment or athletic related/required. Limit of one physical per member per year.	20%, no deductible, excluding travel, employment or athletic related/required. Limit of one physical per member per year.	20%, after deductible, excluding travel, employment or athletic related/required. Limit of one physical per member per year.
Second Surgical Opinion	Voluntary. Paid according to normal plan benefits when received from plan provider.	Voluntary. Paid according to normal plan benefits.		Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.
Speech Therapy	\$10.00 copayment per visit. Maximum 60 visits per member per year.	10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.
TMJ	Not covered.	10%, deductible waived in office setting.	20%, after deductible.	20%, no deductible.	20%, after deductible.
Well Child Care	\$10.00 copayment per visit.	10% to 7 years. Deductible waived in office setting.	20%, to 7 years. No deductible.	20%, to 7 years. No deductible.	20%, to 7 years. No deductible.
X-Ray and Lab	0%.	10%, deductible waived in office setting.	20% after deductible.	20%, no deductible.	20%, after deductible.
<b>MENTAL HEALTH/SUBSTANCE ABUSE</b>					
Inpatient Hospital Room & Board	0%.	10%, after deductible.	20%, after deductible.	20%, after deductible.	20%, after deductible.
Inpatient Physician Care	0%.	10%, after deductible.	20%, after deductible.	20%, after deductible.	20%, after deductible.
Outpatient	\$10.00 copayment per visit.	\$15 copayment once per date of service; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket limit.</b> 10% coinsurance, deductible waived in office setting for other office services.	\$15 copayment once per date of service; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket limit.</b> 20% coinsurance, after deductible, for other office services.	\$15 copayment once per date of service; no coinsurance, no deductible. <b>Copayment does not apply to out-of-pocket limit.</b> 20% coinsurance, no deductible for other office services.	20%, after deductible.

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<b>PRESCRIPTION DRUGS</b>					
<b>Retail</b>					
Quantity	30-day supply per copay.	30-day supply per copay.	30-day supply per copay.	30-day supply per copay.	30-day supply.
Preferred Generic Drugs	\$5.00 copay for each prescription or refill.	\$5.00 copay for each prescription or refill.	\$5.00 copay for each prescription or refill.	\$5.00 copay for each prescription or refill.	20%, after deductible.
Preferred Brand Name Drugs	\$15.00 copay for each prescription or refill.	\$15.00 copay for each prescription or refill.	\$15.00 copay for each prescription or refill.	\$15.00 copay for each prescription or refill.	20%, after deductible.
Non-preferred Generic and Non-preferred Brand Name Drugs	\$30.00 copay or 25%, whichever is greater, for each prescription or refill.	\$30.00 copay for each prescription or refill.	\$30.00 copay for each prescription or refill.	\$30.00 copay for each prescription or refill.	20%, after deductible.
<b>Mail Order</b>					
Quantity	90-day supply per copay.	90-day supply per copay.	No out-of-network coverage available.	90-day supply per copay.	No mail order benefit available.
Preferred Generic Drugs	\$10.00 copay for each prescription or refill.	\$10.00 copay for each prescription or refill.		\$10.00 copay for each prescription or refill.	
Preferred Brand Name Drugs	\$30.00 copay for each prescription or refill.	\$30.00 copay for each prescription or refill.		\$30.00 copay for each prescription or refill.	
Non-preferred Generic and Non-preferred Brand Name Drugs	\$60.00 copay for each prescription or refill.	\$60.00 copay for each prescription or refill.		\$60.00 copay for each prescription or refill.	
<b>Specialty Drugs</b>					
Quantity	30-day supply per copay.	30-day supply per copay.	30-day supply per copay.	30-day supply per copay.	30-day supply.
Retail	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.	20%, after deductible.
Mail Order	No mail order benefit available.	No mail order benefit available.	No mail order benefit available.	No mail order benefit available.	No mail order benefit available.

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Prescription Drug Benefit – General Information					
Pharmacy Out-of-Pocket Maximum	No separate out-of-pocket maximum. Copayments do <b>NOT</b> apply to medical out-of-pocket maximum.	Single \$250 Family \$500  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. (This out-of-pocket limit is <b>separate</b> from the medical out-of-pocket.)		Single \$250 Family \$500  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. (This out-of-pocket limit is <b>separate</b> from the medical out-of-pocket.)	No separate out-of-pocket maximum.
Prescription Oral Contraceptives and Contraceptive Devices	Covered.	Covered.		Covered.	Covered.
Prescription Drug Coverage – Additional Information	Prescription must be for a covered service and from a plan pharmacy. No ancillary charges may be assessed.	If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay <b>and</b> any difference between the billed charge for the brand name drug and the billed charge for the generic.		If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay <b>and</b> any difference between the billed charge for the brand name drug and the billed charge for the generic.	

NOTE: The Wellmark Blue Cross and Blue Shield (BCBS) plan's coverage percentage for hospital and other facility services does not reflect the actual payment to the provider. The actual payment to the provider is based on BCBS's contract with the provider. The percentage is used in this document for comparison purposes only. On any given claim, the amount represented by the coverage percentage times the covered charge may be satisfied by BCBS's payment to the provider plus any amounts the provider agrees to waive under its contract with BCBS. Please see your benefits booklet for more information.